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Barriers to accessing mental health services by the Hmong

By

Pajtshiab Ly, BSW, LSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work

St. Catherine University and the University of St. Thomas Twin Cities, Minnesota
In Partial fulfillment of the Requirements of the Degree of
Master of Social Work & Master of Holistic Health Studies

Committee Members
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation

Abstract

With the consistently growing population of Hmong Americans, this study will contribute to the few research articles that exist and serve to promote more thorough understanding of mental health needs in the Hmong community, with greatest emphasis on highlighting current barriers to accessing mental health care. The goal of this study is to retrieve and examine research on Hmong mental health concerns, barriers to addressing those concerns in mental health treatment settings, and to provide an analysis of findings. The research question focuses on: What are the obstacles that deter the Hmong from utilizing mental health services? This systematic review synthesized relevant research to identify the barriers to seeking mental health services for the Hmong. Articles pertaining to the Hmong population, specifically around mental health services were selected through inclusion and exclusion criteria. After conducting analysis of the literature, six interrelated themes emerged as indicators of obstacles to seeking mental health services for the Hmong: 1) cultural practices and beliefs, 2) mental health literacy, 3) language barriers, 4) stigma, 5) accessibility and affordability and 6) trust.

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Introduction

As the country's cultural diversity grows, it is essential that mental health agencies work to understand and respond to the changes in their communities' demographics. While formal mental treatment options are based on a western medical model, the arrival of immigrant and refugee communities, each possessing their own values, social structures, and beliefs, necessitates culturally responsive shifts in the delivery of mental health services. Without such shifts, various barriers interfere with communities' abilities to access appropriate care to address significant mental health concerns related to surviving individual and historical trauma, acculturation challenges, and ongoing micro aggressions.

There has been an increased research focus on Hmong Americans in recent years. Despite this increase, however, only a few scholarly articles exist on the topic of Hmong and mental health. Even fewer research efforts delve into the topic of barriers to accessing mental health services for members of the Hmong community (S. Lee, 2013). A qualitative study conducted by Chung & Lin (1994), involving Southeast Asian groups indicated that the Hmong were least likely to utilize western health services as compared to other Southeast Asian groups. The data in this study yield that 88% of Cambodian and 86% Laotian utilized western health services whereas only 56% of Hmong indicated the utilization of western health services. Due to limited research on the topic of Hmong mental health, there is debate about whether lower utilization rates of mental health services are due to less need for mental health care or if they are a reflection of extensive barriers experienced by the Hmong community (Thao, Leite & Atella, 2010).

The purpose of this research is to examine barriers to mental health services by the Hmong community: a cultural group that originally sought refuge in the United States in 1975.

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As the Hmong community strives to be more visible, in this nation's policies, history lessons and common knowledge, scant research exists to fully understand and address the obstacles that limit access to needed mental health care. A systematic review will, therefore, be conducted in the hopes of synthesizing knowledge and understanding in a cohesive way to shine light on growth areas for improved culturally responsive mental health services.

History and Background of the Hmong

There are no actual documents or anthropological studies done to trace the original roots of the Hmong people, but information has been passed down many generations, through the oral storytelling of elders and the use of needlework/flower cloth. Archaeologists have theorized that the history of the Hmong people dates back into the early 5,000 BCE in central China (Minnesota Historical Society, 2014). Throughout history, the Hmong, which means "free people," have constantly migrated due to oppression, discrimination and hostile persecution from the Chinese. Due to constant warring, the Hmong people migrated out of China and into Northern Vietnam in the late 18th and early 19th centuries and into Laos the second half of the 20th century (Barney & Yang, 1979).

The Hmong and their involvement in the Vietnam War

While the Vietnam War was under way, the United States and twelve other nations signed a neutrality treaty in 1962, stating that Laos would remain neutral and all troops from foreign countries had to withdraw out of the country (Leary, 2008). When North Vietnam broke the treaty and led their troops along the southern border of Laos, through a route known as the Ho Chi Minh Trail, the U.S. covertly responded. This secret assignment was handed to a CIA

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agent who worked with General Vang Pao to recruit the Hmong people as foot soldiers for the U.S. (Leary, 2008). Tired from ongoing persecution and longing for greater autonomy, the Hmong people collaborated with the U.S.: they received warfare supplies, military training, food and air support as they intercepted on the Ho Chi Minh Trail. The Hmong people also used their expertise in navigating the humid, tropical, mountainous terrain of the country and rescued, treated, and sheltered many American pilots who were shot down.

As shifts in Laotian government and leadership occurred, General Vang Pao became concerned about the safety of his family and the Hmong people (P. Vang, 1981); he subsequently resigned. In 1975, about 2,500 Hmong military families were airlifted from the military base of Long Cheng (Minnesota Historical Society, n.d.), while the remaining Hmong people had to travel through the jungle to Vientiane and cross the Mekong River into Thailand in order to escape persecution for having helped the Americans.

The immediate repercussions facing the Hmong were severe. Anyone associated with Vang Pao forces and the Americans were branded as “tools of the CIA” or “lackeys of the American Imperialism.” Men, women, and children were shot, disappeared, or sent to labor battalions, from which most never returned. Some Hmong drowned in the Mekong River. For those who made it to Thailand, long waits to be classified as refugees from the Thai government meant that, by the time they could return to Laos to pick up the rest of their families, their families might have been killed. (Williams, 1978).

To appreciate the lived experiences of the Hmong community, contemporarily and throughout history, it is important to examine the political landscape that contributed to migration waves of Hmong people to the United States. The population of the Hmong in the

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United States has significantly increased in the past four decades. In 1975, after the United States pulled out of the Secret War and Laos fell into the hands of Communists, the first wave of Hmong refugees arrived in America (Minnesota Historical Society, 2014). Following that, U.S. Congress passed the 1980 Refugee Act which allowed many more Hmong families to enter America (Minnesota Historical Society, 2014). In 2013, American Community Survey collected data showing the Hmong population at 286,211 (Pfeifer, M. E., 2014). Minnesota, California and Wisconsin are the most densely populated states with Hmong families. Adjusting to their new life in America was a challenge as they had to learn new skills while maintaining their culture and beliefs (T. Lee, 2010). A longitudinal study of questionnaire and self-rating scale study was conducted by Westermeyer et al. (1989) involving Hmong participants, ages 16 years or older and living in Minnesota, indicated that many Hmong refugees have remarkably adjusted in the United States, however, symptoms of depression remain high.

Effects from war, acculturation and the prevalence of mental illness

Due to the war, many Hmong individuals struggled with locating families and extended families who were valuable sources of emotional and economic supports (Cerhan, 1990). Although many of them relied heavily on the government for financial aid, they faced many struggles in basic needs such as language barriers, ESL/Education, employment/transportation, culture shock and housing (P. Vang, 1981). A cross-sectional survey conducted by Nicolson (1997) with 447 Southeast Asian refugees and immigrants (Hmong were included in sample size) indicated that Southeast Asian refugees and immigrants exhibited psychiatric issues during pre and post emigration. Nicolson (1997) identified that acculturation was a stressor that impacted the mental health status of these refugees.

Acculturation. Acculturating to their new life in America proved challenging for the Hmong people. A quantitative research study involving Hmong individuals, ages 16 years or older groups, conducted by Westermeyer (1988) discovered that many Hmong individuals suffered from chronic adjustment disorder or chronic acculturation syndrome. Various factors contributed to these difficulties adjusting to urban life, including: agricultural background, historic lack of opportunity for formal education, illiteracy in Hmong and English, physical and emotional trauma linked to dislocation from the war, cultural fragmentation and social disruption that impelled high rates of posttraumatic stress disorder, depression and other psychological conditions (Barret et al., 1998).

In comparison with the other Southeast Asian refugees and the U.S. general population, higher rates of mental health disorders were found among the Hmong population even after resettlement (Westermeyer, 1988; Lee & Chang, 2012a). Many Hmong individuals continue to be affected from war injuries such as exposure to chemical warfare, chronic pain from bullet and shrapnel wounds, and psychological conditions (Johnson, 2002). Over the decades, cultural practices have also shifted rapidly including changes in family dynamics where gender roles have been reconstructed and identity crises in adolescents have contributed to social and mental health concerns in the Hmong community (Collier, Munger & Moua, 2011). Many of these challenging changes reflect the society in which the Hmong people now live.

Acculturation rates may vary within refugee or immigrant family members and may create changes in the family structure. According to Chung & Bemak (2006), “Similar to immigrants, refugee children and adolescents tend to acculturate faster than their parents, which also contributes to changing roles and shifting family dynamics,” (p. 155). A qualitative study

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conducted by Mescheke & Juang (2013) involving Hmong adolescents and their parents indicated generational cultural differences between the adolescents and their parents. The Hmong adolescents in this study indicated that their parents did not understand their experiences because they grew up in a different environment (Mescheke & Juang, 2013). Tatman (2004) indicated that Hmong traditions are maintained by Hmong elders whereas the younger Hmong generations are slowly adapting to Western culture and customs. Tatman (2004) goes on to say that the disparity in acculturation may cause younger Hmong to experience familial stress and intrapersonal conflict by having to choose one culture over the other and may lead them to feeling isolated from their family members.

Another change and potential conflict within the family structure is the reversal of gender roles. Hmong men usually play bigger roles in the family unit as status is ranked by gender and age (T. Lee, 2010). The Hmong follow a patriarchal culture where the husband is expected to financially provide for his family. A qualitative study conducted by T. Lee (2010) involving Hmong men ages 35 to 65 indicated the pressure to be strong and be able to provide for their families and any signs of weakness may bring shame to their family name weighed heavily on the participants' shoulders. However, in the United States, Hmong women may possess more marketable and employable skills such as caretaking, cleaning and garment making compared to Hmong men (Cerhan, 1990). According to Chung & Bemak (2006), "working outside of the home and community and being exposed to American culture, refugee women may begin to question their traditional cultural gender roles and see more independence," (p. 154) and "such shifts in roles and attitudes frequently may cause martial conflicts," (p. 154).

According to Lee & Chang (2015), as cited by Kunstadter (2000) “wrote a testimony to the Commission on Asian Americans and Pacific Islanders that addressed how the Hmong suffered higher rates of mental health issues,” (p. 59). Headlines and the media of extreme familial violence validated this statement when *The New York Times* (1998) reported on a Hmong American man from California who was mentally distressed from chronic adjustment difficulties that limited his employment abilities ended up murdering his five children and then committing suicide afterwards (Lee & Chang, 2015). Another report completed by *The New York Times* (1998) focused on a story of a Hmong woman in Minnesota who endured abused her entire life ended up strangling her six children to death as a result of her lifeline issues (Lee & Chang, 2015). CBS Sacramento (2011) reported on a Hmong woman who microwaved her six week old baby and after a three-month long investigation, she indicated to authorities that she may have split personality. The Fresno Bee (2016) covered the story on a Hmong man in California who murdered his wife for seeking divorce then tried to commit suicide but was unsuccessful.

Hmong Worldview of Healing Practices and Cultural influences

According to Aerts et al. (1994), worldview is defined as “a coherent collection of concepts and theorems that must allow us to construct a global image of the world, and in this way to understand as many elements of our experience as possible” (p. 8). The Hmong have a different belief system of psychological well-being (Barrett et al., 1998). The Hmong believe that spirits are all connected to living things and causation of illnesses may be influenced by the imbalance of spirits (Cobb, 2010). They believe that an individual has three souls, in the head, torso and leg and all three must be balanced or reunited to have good health, especially good

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mental health (Bliatout, 1985). If symptoms of illness surface, the Hmong would usually seek advice from traditional healers such as shamans for a diagnosis and treatment.

Healing practices. Understanding the human body, in scientific terms, can be a challenge to the Hmong as they have had little exposure to modern medicine and education in the past. The medical terminologies are very limited in Hmong because such terminology is derived from western medical practices. To translate an English phrase about a malfunctioning organ, for example, would require extensive description, utilizing many words and strategies to explain the complex concept in ways that would be understood by the Hmong patient (Johnson, 2002).

Traditional Hmong families worship ancestors and believe that the cause of mental health conditions derive from religious problems. To have good physical and mental health, it is believed that all souls must solidify with the human body. A loss of one's soul or souls or encounters with other spirit entities could result in mental health symptoms such as depression, delusions, loss of appetite, nightmares, changes in behaviors (Bliatout, 1985). In order to address those challenges, traditional Hmong families seek assistance from traditional healers such as Shamans, Herbalists or Masseuses before seeking western mental health services (Alisa, 2007). According to a qualitative study conducted by Chung & Lin (1994) involving Southeast Asian groups (including Hmong participants in the sample size) indicated that the Hmong were least likely to utilize Westernized treatments and preferred to seek treatment from traditional indigenous healers. According to Lee & Pfeifer (2006), the continuation of traditional methods of healing are prevalent in 70% of Hmong in the United States.

To determine the individual's illness, the Shaman performs an initial ceremony to diagnose the cause of the illness by traveling to the spirit world. It is in the spirit world that the

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Shaman will find out what actions (described as payments) must to be done to pacify the spirit that is causing the illness. The second ceremony is when the Shaman will travel back into the spirit world to negotiate payments to cure the illness where usually an animal such as a chicken, pig or cow is often sacrificed (Johnson, 2002).

According to Alisa (2007), non-traditional Hmong families who have converted to Christianity or other religions may seek healing in a different way than traditional families by utilizing their church and prayers. After exhausting all religious options, some Hmong families, particularly those who are more fully acculturated are open to seeking mental health services (Alisa, 2007). Western mental health services are typically the last resort for both traditional and non-traditional Hmong families (Alisha, 2007). A qualitative study conducted by Gensheimer (2006) involving Hmong mental health providers indicated that many of their Hmong patients would come see them as a last resort or when mandated by the court. In the same study, Hmong mental health providers indicated that Hmong adults believed that medication or herbs could heal them better than meaningless “talk therapy.”

Cultural influences and stigma. The Hmong are a patriarchal collective community and decisions for an individual around personal issues are usually determined after consultation with close family members. Medical decisions are usually determined after consulting with family members and clan members as they are valued highly within the Hmong community (Barret et al., 1998). Disclosing personal information, especially about negative behaviors could expose vulnerability and bring shame to the individual and affect family clan name (Meschke et al., 2013). Seeking help outside of family is not encouraged as it is seen as a sign of weakness, which may discourage many Hmong individuals (T. Lee, 2010). Stigma is associated with

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mental health illness and may be a factor that can bring shame to family clan name. A qualitative study conducted by Greenwood et al. (2000) involving 24 Asian in-patient patients indicated that stigma was associated with mental health. The data in this study yield that many caregivers did not disclose about their family member receiving in-patient mental health services due to the stigma associated with mental health. A qualitative study conducted by K. Vang (2010) involving Hmong adolescents indicated that the influence of perceived stigmatization (such as embarrassment or parents and friends finding out) prevented them from utilizing mental health services.

Methodology

The goal of this systematic review is to retrieve and examine research on, barriers to mental health for the Hmong population in the United States. The research question will focus on doing a systematic review of the research literature on the obstacles that deter the Hmong from utilizing mental health services.

A systematic review was conducted of research articles that focus on the Hmong's utilization of mental health services in the United States. A systematic review involves the synthesizing of research literature on a certain topic. Systematic review of literature allows researchers to gather articles with the aim of exploring current knowledge and common understandings of similar topics, which may improve the practice of social work. The target of this systematic review was to synthesize relevant research literature to identify the barriers that deter the Hmong from seeking mental health services in the United States.

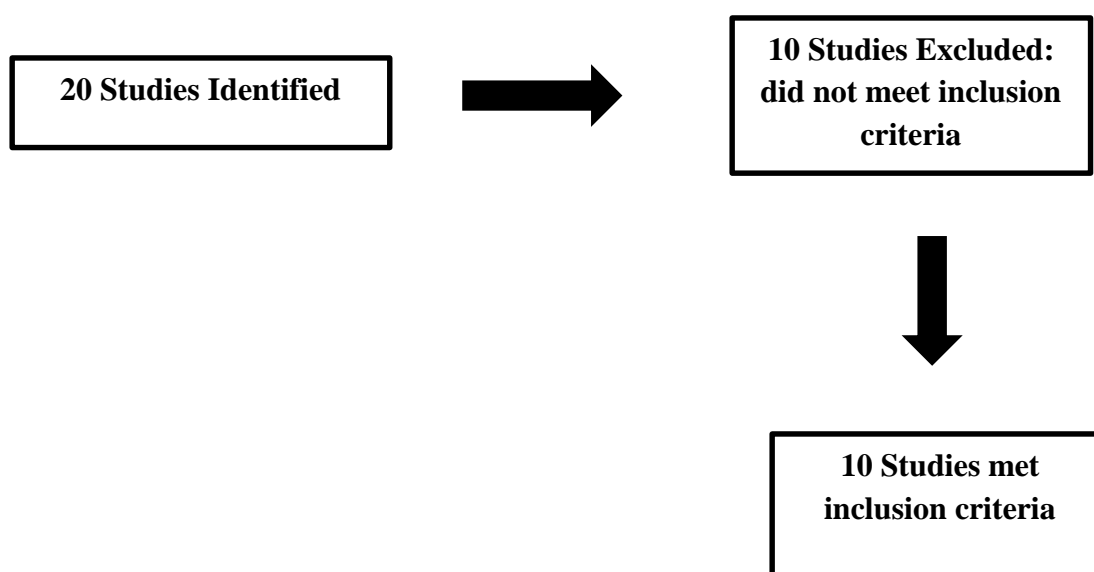
Inclusion Criteria. Due to the limited amount of articles written on this subject, articles dating as far back as 1985 were considered for the study. Other inclusion criteria include 1) a clear description of the sample size; 2) the sample size must include participants of Hmong descent; 3) the sample size must be large enough to produce results generalizable to the broader Hmong population; 4) the content must pertain to help-seeking behaviors; 5) the content must pertain to barriers accessing mental health services; and 6) the content must also pertain to Hmong health.

Search Process. The search engines utilized to find academic research articles were: Google Scholar, Psynet, St. Thomas library: social work abstracts and google. The key terms used to narrow the search were: Hmong mental health; barriers to mental health for the Hmong; help-seeking behaviors; Hmong health. The articles needed to meet the inclusion criteria to be

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selected for further analysis. There were 20 articles that pertained to Hmong and mental health services and medical health services. Half of the articles discovered were excluded as they did not meet the inclusion criteria listed above and did not pertain to the focus of the study. Table 1 below shows how researcher dictated the flow of this research:

Table 1 (Flow of how articles were selected)



Findings

A systematic review of the literature was employed to identify the contributing barriers that deter the Hmong people from seeking mental health services. After utilizing the search databases of Google Scholar, Psychnet, and University of St. Thomas library: social work abstracts, 10 peer-reviewed articles and dissertations met the inclusion criteria and were selected for further examining as shown below in Table 2. Of the 10 articles selected, eight (80%, $N = 8$) were centered on mental health services and two (20%, $N = 2$) were centered on medical health care services. All selected articles consisted of participants whom were of Hmong descent in the sample sizes. Of the 10 articles, two articles (20%, $N = 2$) included other Southeast Asian groups within the sample sizes.

Table 2: Articles Selected for the Systematic Review

| Article | Purpose/ Hypothesis | Sample | Method | Results | Limitations |
|--|--|---|---|--|------------------------------|
| Gensheimer, L. (2006). <i>Learning from the experiences of Hmong mental health providers.</i> | Interviews were conducted with mental health providers who were Hmong to explore the meaning of what it was like to a Hmong mental health provider. | 11 Hmong mental health providers were interviewed. | A hermeneutic phenomenological study was conducted to explore and learn the experience of what it means to be a Hmong mental health provider. | Five major themes (The clash, I call him uncle, deciphering the code through Hmong embeddedness, Tshuaj Vwm (Crazy Medicine) and in my heart, I can see it that way) that were interconnected with one another emerged as participants discuss their struggles and successes in practice with Hmong and non-Hmong clients. | None were listed in article. |
| Chung, R. & Lin, K. (1994). <i>Help-seeking behavior among Southeast Asian refugees.</i> | This research examined the differences in the help-seeking behaviors of five Southeast Asian groups' (Vietnamese, Cambodians, Lao, Hmong and Chinese | The sample of 2,773 consisted of Hmong ($N = 302$), Cambodians ($N = 590$), Vietnamese ($N = 867$), Lao ($N = 723$) and | Participants were asked a series of questions regarding their method in treating health problems in their home country and in United States. | The results indicated that the Hmong were least likely to utilize Western medicine in their home country and in the United States compared to the other four Southeast Asian groups listed. | None were listed in article. |

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| | Vietnamese) in the United States and in their home country. | Chinese Vietnamese (N = 291). | | | |
| Johnson, S. (2002). <i>Hmong health beliefs and experiences in the western health care system.</i> | An ethnographic study was conducted to determine the Hmong perspectives and beliefs that influence their experience in Western medical situations. | Two focus groups that consisted of Hmong participants were in this study. | Observations and interviews were conducted with Hmong participants in the focus groups. Data were collected over a 2 year time frame and discussed and confirmed with both Hmong men and women who worked at the clinic. | The data collected indicated that the Hmong language lacked terminologies in translating medical terms. The data also indicated that Hmong members tend to not trust or fear western medicine due to negative past health care experiences. | None were listed in article. |
| Lee, H.Y., Lytel, K., Yang, P. and Lum, T. (2010). <i>Mental health literacy in Hmong and Cambodian elderly refugees: a barrier to understanding, recognizing and responding to depression.</i> | This study was conducted to explore the mental health literacy among Southeast Asian elderly refugees in the Twin Cities. 3 focus groups held with nine mental health professionals who with SEA elders. | There were three focus groups with nine mental health professionals who worked with Southeast Asian elders. | Jorm's mental health literacy framework was utilized to guide the study theoretically. Interviews were semi-structured and included open-ended asking participants about their understanding of mental health literacy and cultural beliefs and coping skills. Qualitative data analysis was conducted once data was collected. | Results indicated four themes that may influence the lack of utilization in mental health services for the SEA elderly population: lack of knowledge of specific mental disorders, culture beliefs of mental disorders, lack of awareness of professional help and cultural attitudes towards seeking mental health services. | Small sample size of health professionals working with SEA elderly populations. Grouping of Hmong, Cambodian and Vietnamese elders together as each group has their own beliefs and values. |
| Collier, A. F., Moua, Y. K. and Munger, M. (2011). <i>Hmong mental health needs assessment: A community-based partnership in a small mid-western community.</i> | This study was conducted to identify the mental health needs in order to provide mental health services for the Hmong people in the Midwest community. | A sample size of 64 that consisted of four focus groups (N = 36) men, women, adolescents and (N = 28) medical, mental health, education, social service providers, all of Hmong descent. | Interviews consisted of semi-structured questions that focused key issues to mental health access and treatment. Questions were translated in focus groups since not all participants spoke/understood English. | Results indicated that was a lack of knowledge of the procedures of mental health services/treatment. Many participants were confused about mental health symptoms and couldn't distinguish between psychological and psychiatric symptoms. | Selection of participants were hand-picked based on demographics. Participants selected could have been clients in most need of mental health care. Participants were awarded with a stipend which could have attracted participants who were financially burdened and distressed. |
| Meschke, L. L. and Juang, L. P. (2014). <i>Obstacles</i> | This study was conducted to explore the | A sample sized consisted of | A pilot study between May and September of 2008 | The results indicated that adolescents had difficulty with communicating with | Study reflects just young adult's views of |

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|---|--|--|--|--|---|
| <i>to parent-adolescent communication in Hmong American families: exploring pathways to adolescent mental health promotion.</i> | limited understanding of parent-adolescent communication in Hmong families and its influences on mental health challenges. | 30 young adults (ages 18 to 25 years old), 15 females and 15 males, all of Hmong descent participated in the study. | consisted of open-ended questions encouraged participants to share their personal experiences. | their parents due to emotional discomfort and fear of misunderstandings from their parents. Twenty of the participants indicated that obstacles in communicating with their parents seem to originate from traditional Hmong culture/values. | communication between adolescent and parents. |
| Barrett, B., Shadick, K., Schilling, R., Spencer, L., Rosario, S., Moua, K. and Vang, M. (1998). <i>Hmong/medicine interactions: improving cross-cultural health care.</i> | This study was conducted to identify specific factors that may be an obstacle in the delivery of health care by examining the interactions between Hmong patients and their health care providers. | A sample size of 23 Hmong patients and 18 health care providers and 6 translators. | Interviews consisted of semi-structured, nonjudgmental grand tour and open-ended questions to investigate patients and providers experiences for attitudes, ideas or behaviors that could modify to improve the delivery of health care. | The results indicated there were difficulties in understanding each other's health belief systems between Hmong participants and US trained health care providers. There were language and cultural translations that were seen as problematic. | None were listed in article. |
| Vang, K. (2010). <i>Mental health: identifying barriers to Hmong student's use of mental health services.</i> | This study was conducted to investigate the effects of perceived stigmatization and acculturation on student's attitudes toward seeking mental health services. | The sample size consisted of 89 high school students: females (N = 38 and males (N = 51) and their guardians: fathers (N = 51), mothers (N = 37) and guardian (N = 1), all of Hmong descent. | Instruments were utilized to collect demographics, levels of acculturation (SL-ASIA), assess elements of stigmatization (ATMHP), and students attitudes towards seeking mental health services (ATSPPH-SF). Questionnaires were also developed to identify attitudes and barriers towards the use of mental health services. | The results yield that the Hmong youths' perceptions of mental health stigmatization positively related to their communities/families' stigmatization of mental health. Hmong youths' perceptions of difficulty level in making appointments were positively related to their attitudes towards seeking mental health services. | Unknown reading skills of participants as 2 students' questionnaire were removed due to difficulty with reading. Only 5 students requested for assistance (which was provided) whereas others may not asked due to carelessness or embarrassment. Study was homogenous and consisted of second generation bi-cultural students only. Instrument (SL-ASIA) utilized may not be as effective as the Hmong group are different |

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|--|--|---|---|--|--|
| | | | | | from other Asian groups due to their limited exposure to Western culture. |
| Lee, T. (2010). What are the barriers to first generation non-Christian Hmong men ages 35 to 65 seeking mental health services? | This study was conducted to explore the barriers that prevent first generation non-Christian Hmong men, ages 35 to 65, from seeking mental health services. | A sample of ten first generation non-Christian Hmong men (ages 38 to 65) participated in the study. | A snowballing technique was utilized to recruit participants. A qualitative method with open-ended questions in both English and Hmong were utilized. | Results yield three themes that deter the participants from seeking mental health services: perceived ineffectiveness of mental health services, language barriers and role identities/expectations. | Small sample size. Snowballing sampling may have limited recruitment of participants. |
| Vang, M. (2011). Cultural and environmental factors that help or deter Hmong from seeking mental health services. | This study was conducted to understand and identify environmental, cultural and personal factors that influences the Hmong population from seeking mental health services. | A sample size of 43 individuals that consisted of males (N= 24), females (N = 17 and anonymous (N = 2) participated in the study. | A quantitative study was utilized to identify the barriers to seeking mental health services among the Hmong population. Flyers were distributed for participants to participate in an online survey. | Results indicated that stigma and lack of mental literacy was a factor that prevented participants from seeking mental health services. | Snowballing sample size may have prevented from recruiting larger population. Small size sample. Time constraint was a limitation. Study limited non-English speakers as survey was completed only online. |

Summary of Research Articles.

As noted in the chart above, research articles range from 1994 to 2014. Various methods including semi-structured open ended questions and focus groups were utilized to retrieve qualitative data and special designed instruments were utilized to collect quantitative data. Majority of the sample sizes included participants who were of Hmong descent. Limitations were often omitted from discussion. For research that addressed limitations, common themes included small sample size, unknown reading skills of participants, time constraint and limitation of non-English speakers.

The most prominent research data collected in the articles reviewed were qualitative (80%, N = 8) with quantitative falling short (10%, N = 1) and one article utilizing both qualitative and quantitative approaches (10%, N = 1). In all of the studies conducted, interpreting services were offered to participants with limited English speaking skills. The majority of the reviewed articles (90%, N = 9) utilized semi-structured, open-ended questions to obtain their data. The remaining article (10%, N = 1), *Cultural and Environmental factors that help or deter Hmong from seeking mental health services* by M. Vang (2011), collected quantitative data by distributing flyers to conduct an on-line survey. The three articles: *Hmong health beliefs and experiences in the western health care system* (Johnson, 2002), *Mental health literacy in Hmong and Cambodian elderly refugees: a barrier to understanding, recognizing and responding to depression* (Lee et al., 2010) and *Hmong mental health needs assessment: A community-based partnership in a small mid-western community* (Collier et al., 2011), all utilized semi-structured and open-ended questions in focus groups which consisted of participants who were men, women, adolescent and elderly. All focus groups were separated by gender, age and ethnic background.

Of the three articles involving focus groups, one article, *Mental health literacy in Hmong and Cambodian elderly refugees* (2010) by Lee et al., demonstrated a commitment to deeply understanding the mental health literacy in measurable ways by utilizing a mental health literacy framework developed by Jorm (1997) to theoretically guide the study (Lee et al., 2010). Lee et al (2010) indicated that Anthony Jorm and colleagues (1997) developed the mental health literacy concept that contained six components to expand awareness of mental health illness. The six components according to Jorm (2000) include a) knowledge that allows one to identify specific disorders, b) knowledge and beliefs regarding causes and risk factors, c) knowledge and beliefs

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about self-help recognition and help seeking, and f) knowledge of how to seek mental health information (Lee et. al., 2010). Lee et al. (2010) indicated that according to Jorm (2000) mental disorders cannot be understood or recognized if individuals cannot understand psychiatric terms or seek help to treat their mental illness. Lee et al. (2010) also indicated that by utilizing this tool, researchers are able to articulate various challenges community members experience in understanding the concept of mental health illness and services, which, many argue, is a fundamental step to seeking mental health care.

The article, *Learning from the experiences of Hmong mental health providers* by Gensheimer (2006), conducted a hermeneutic phenomenological method to discover, explore and learn from lived-experiences with mental health providers who were Hmong. Gensheimer (2006) cited from (van Manen, 1997) that a hermeneutic phenomenology studies the lived-experiences through the interpretation of descriptive texts. One dissertation, *Mental Health: Identifying Barriers to Hmong Students' use of mental health services* conducted by K. Vang (2010), utilized both questionnaires and measuring instruments to collect quantitative and qualitative data from adolescents and their parents. The instruments used to measure quantitative data were as listed: the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) created by Suinn, Ahuna and Khoo (1992) was utilized to measure levels of acculturation; Attitudes Towards Mental Health Problems Scale (ATMHP) created by Gilbert et al. (2007) was utilized to measure levels of stigma towards mental illness; Attitudes Toward Seeking Professional Psychological Help Scale: Short Form(ATSPPH-SF) created by Fischer and Farina (1995) was utilized to measure perceptions towards seeking mental health services and to measure mental health barriers, questions from the Massachusetts Institute of Technology Mental health Task Force Report (2001) were utilized (K. Vang, 2010).

While the purpose of this research was to identify the factors that discouraged the Hmong people from seeking mental health services, each of the eight of the articles shed some light on their experiences and perceptions towards mental illness and mental health services. The two articles that focused on the utilization of medical health care services were integrated into this review, since the Hmong's perceptions of physical and mental well-being are inextricably linked. Of the two articles: *Hmong health beliefs and experiences in the western health care system* (2002) by Johnson and *Hmong/medicine interactions: improving cross-cultural health care providers* (1998) by Barrett et al. that focused on the utilization of medical health care services, *Hmong/medicine interactions: improving cross-cultural health care providers* (1998) by Barrett et al. explored the factors that may be barriers in the delivery of health care by investigating the interactions between Hmong patients and their health care providers.

Analysis of Themes

After dissecting the articles and throughout the research, six integrative key themes emerged around the barriers that deter the Hmong people from seeking mental health services. These themes include; 1) cultural beliefs and practices; 2) mental health literacy; 3) language barriers; 4) stigma; 5) affordability and access and 6) trust.

Cultural practices and beliefs. Cultural practices and beliefs was a common theme that frequently emerged throughout the articles reviewed. Eight articles (80%) indicated that cultural perceptions and beliefs of illness were factors that hindered the Hmong from seeking mental health services. In a qualitative study, *Mental health literacy in Hmong and Cambodian elderly refugees* (2010), Lee et al. contends that seeking help for depression symptoms were not sought after because depression was not recognized by Hmong elderly, instead it is believed that the

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symptoms of depression were caused from external causes. For example, a participant, a mental health social service provider, indicated, “They (the elders) tie depression to a situation (as a cause), not as a chemical imbalance or anything like that. Yeah, that’s why they won’t agree to medication, because medication’s not going to fix their kids’ behavior or anything like that,” (Lee et al., 2010, p. 336). Due to the lack of medical terminology in the Hmong language, the Hmong elders would describe their depressive symptoms in terms of psychosomatic symptoms. For example, “focus group members acknowledge that their elderly clients described depressive symptoms using physical complaints based on their culture beliefs of mind and body connection; these symptoms include difficulty with sleeping, frequent nightmares, body aches or pain, loss of appetite, lack of energy and other physical ailments,” (Lee et al., 2010, p. 332). Lee et al (2010) also emphasized that some Hmong elders believed that their symptoms of depression would be best treated by a traditional shaman healer instead of a psychiatrist. They believe that a traditional shaman healer can offer a better explanation of symptoms as they are able to communicate in the same language and understand the same culture versus in western mental health providers who tend to explain symptoms of depression from a biological perspective (Lee, et al., 2010). For example,

“...one of the (elder’s ... most frequent) complaints is that the psychiatrist does not give explanation(s) like the shaman would. The shaman would say (“the situations is that) your ancestor is here,” or “it’s something in your body that needs correction,” and that’s a reasonable explanation for them. Whereas the psychiatrist just (says), “um hmm, um hmm,” and then he writes a prescription. Well, it doesn’t explain how the prescription is going to help this problem because...they psychiatrist didn’t even say what the problem was...” (Lee et al., 2010, p. 336).

The Hmong did not believe that a chemical imbalance internally may be a factor to mental illnesses instead they believed that mental health symptoms originate from the loss of the soul (Gensheimer, 2006). The Hmong believed that seeking a shaman for consultation or treatment can heal or cure the mental illness symptoms faster. For example, in a study conducted by T. Lee (2010), “all ten of the respondents stated they do not believe mental health services are able to help them, because of their cultural beliefs and experiences with mental health,” (p. 28) and they all indicated that they “believed in shamanism because it had been proven to them that it helped,” (p. 29).

The Hmong people are a collective community and when issues surface, they would traditionally consult with family members first before seeking outside help. According to a quantitative study conducted by M. Vang (2011), about 69.8% of the 43 participants indicated that they would consult with family members if there was an issue that they couldn't resolve on their own whereas 30.2% indicated they would not consult with family members. When asked if participants would seek help from a pastor/shaman/family member/or clan member for issues that cannot be resolved independently, about 53.3% of the 43 participants indicated that they would seek help and 46.5% indicated that they would not seek help (M. Vang, 2011). When asked if any of the participants ever received services from a counselor or mental health provider, about 81.4% of the 43 participants indicated that they never received any services from a counselor or a mental health provider whereas 18.6% indicated they have (M. Vang, 2011). When asked if participants would utilize services from a counselor or mental health provider if needed, 67.4% participants responded that they would and 32.6% responded they would not (M. Vang, 2011). In this study scores from the Belief Towards Mental Illness and the Stigma Scale for receiving Psychological Help scales indicated higher negative stereotypical views of mental

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health (M. Vang, 2011). M. Vang (2011) indicated that even though 67% of the participants indicated that they would utilize mental health services, negative beliefs of mental health illness is still prevalent that may prevent the Hmong from seeking mental health services.

Hmong mental health providers from a qualitative study conducted by Gensheimer (2006) indicated that many of the Hmong participants will seek mental health services as a last resort and will be upset after learning that therapy will not provide a quick fix. Beliefs of symptoms causing mental illness may influence how the Hmong understand and utilize mental health services. For example a participant from this study conducted by Gensheimer (2006) indicated that even though many Hmong people in the community are suffering from PTSD, depression or anxiety, they still believe that these illnesses are not caused from a chemical imbalance. Participants from this study (Gensheimer, 2006) indicated that, “many Hmong adults did not believe they would get better without a tangible remedy such as medication or herbs and that “talk therapy” was seen as meaningless,” (p. 17). For example, a participant in this study (Gensheimer, 2006) named Pong indicated that, “an elderly couple who had come to see him and told him that he was their “last hope” and expressed unhappiness when told he did not have a “cure” for them,” (p. 18).

Traditionally, freedom of expression of opinions or personal issues are not normally encouraged in the Hmong culture especially in women and children which creates obstacles for seeking mental health services. If negative emotions were exposed, research indicated that shame or stigma could be brought to the family. For example, a young adult in a study conducted by Meschke et al. (2013) stated:

“As far as speaking our mind, it’s not stressed. We grow up being in a dependent society of the Hmong culture. We are not supposed to say much. I think that does a lot with the psychological aspects of the young adults,” (p.152).

Another participant from the same study indicated the stigma attached to expression of feelings (Mescheke et al., 2013, p. 152):

“If people hear about that (anger expression) they are going to be like, ‘If she does that then why do I want her as a daughter-in-law.’ You’re not gonna have a husband, or maybe you’ll find a husband but he won’t be as good as you wanted.

Mental health literacy. Mental health literacy was a theme that frequently unveiled in the majority of the articles reviewed. Lee et al. (2010) indicated that Jorm (1997) defines mental health literacy as the comprehension and views of mental illness which assist individuals in detecting symptoms for management or prevention. Jorm (2000) indicated that individuals would not be able to grasp, elicit or seek mental health services if they are unable to identify mental disorders and understand psychiatric terms (Lee et al., 2010). Eight of the articles (80%) indicated that lack of understanding about mental health illnesses, symptoms, terminologies and treatment processes were identified as significant obstacles discouraging the Hmong people from utilizing mental health services.

According to several research articles, Hmong participants struggled with defining mental health illness and identifying symptoms of mental illness. According to the study that Collier, Munger & Moua (2012) conducted with four focus groups, participants indicated that most Hmong “lacked basic knowledge about what mental illness was, or how to recognize early signs”

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and “if given a mental health diagnosis, participants indicated that the Hmong would prefer to have a biological explanation for their behavior and then be prescribed a medical treatment” (p.81). In the study conducted by T. Lee (2010) with first generation non-Christian Hmong men ages 35 to 65, participants were unsure of how to define mental health illness and had difficulty in identifying which symptoms were considered mental illness versus medical illness. For example, a participant indicated that if his physical condition did not get any better, his depression will never go away (T. Lee, 2010). A study conducted by Lee et al. (2010) indicated that many of the elderly participants believed that external circumstances caused their depression and “symptoms of depression are normal reactions to life stressors” (p. 336) and the only way to resolve it would be to change the situation.

Eight articles emphasized that Hmong participants struggled with identifying and understanding mental illness. They also struggled with understanding the procedure and process of mental health treatments. According to a study conducted by Gensheimer (2006), Hmong mental health providers indicated that typically clients will come see them as the last resort after seeking other remedies and expect to be healed within the first or second session. Many participants in the study conducted by Lee et al. (2010) did not seek mental health services for depression, instead utilized their time with their mental health provider to get their basic needs met. For example, many participants in the focus group “mentioned that treatment for depression comes only after the elder’s case management tasks are completed and accomplished” (Lee et al., 2010, p. 335). According to a study conducted by K. Vang (2010) with adolescents, many of the participants expressed that they were unsure of how to make appointments in order to utilize mental health services and worried about confidentiality. According to M. Vang (2010),

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participants indicated their “willingness to seek mental services (67%), however it’s questionable how much the sample understands what mental health services entail,” (p. 45).

Participants also indicated that there was a lack of terminologies in the Hmong language when translating which made it difficult to understand mental or medical illness. According to Johnson (2002), “when asked if they understood the anatomy of the human body, all informants indicated they had no idea what organs were in the body or how the organs functioned,” and “most of the medical and anatomy terms that were used by Western medicine had no words or terms in the Hmong language,” (p. 127). According to Gensheimer (2006), all of the Hmong mental health providers “in this study repeatedly described experiences illustrating that Western mental health concepts are not understood by many within the Hmong community,” (p. 16) and indicated that it would take a much longer time to explain or described the concept as such terms do not exist in the Hmong language.

Language barriers. Language barriers was a theme that interrelated with mental health literacy as the articles reviewed indicated that there were limited mental or medical vocabularies in the Hmong language that made translating difficult to conduct and comprehend. For example, in a study conducted by Lee et al. (2010), a Hmong mental health professional indicated, “the Hmong word for distress doesn’t meet the criteria for depression, so then you have to teach them about the English word depression, but then that criteria doesn’t really fit into the Hmong’s symptomology,” (p. 331). Even some of the best interpreters expressed difficulty with translating diagnosis or treatments from English to Hmong as indicated in a study conducted by (Barrett et al., 1998), “I’m not just interpreting the word, but I’m also interpreting the concept, the theory of the idea, in order get the message across,” (p. 181). Participants indicated that due to language

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barriers, it was difficult for them to disclose personal information to therapists and also expressed the challenges in utilizing interpreters which could lead to mistreatments if the message gets misinterpreted (T. Lee, 2010).

Lee et al. (2010) indicated that language appeared to be a challenge to the participants as the written language for the Hmong recently developed about 50 – 60 years ago. The Hmong people have only been in the United States for about 40 years, which indicates that the written language was only recently developed 10-20 years before their arrival. Based on the given time frame of the development of a written language, there are significant communication gaps between generations (elders, adults and youth) as indicated in the articles reviewed. For example, in a study conducted by Meschke et al. (2014), a participant indicated that, “there’s no definition like depression in the Hmong community so that’s probably one of the reasons why parents can’t really help a teen who’s going through depression,” (p. 152). In a study conducted by T. Lee, (2010), participants indicated the challenges of addressing their needs when utilizing interpreters for therapy sessions. For example, a respondent indicated that “our younger generation (interpreter) nowadays may speak English fluently, but they have forgotten many of the Hmong language and concepts,” and “often times, they do not interpret exactly what we say to the person,” (T. Lee, 2010, p. 31).

Stigma. Stigma was a theme that interrelated with the previous themes listed above: mental health literacy, language barriers and cultural practices and beliefs. Stigma continues to be a barrier to seeking mental health services for the Hmong. According to T. Lee (2010), mental health is a new concept to the Hmong people and the stigma of mental health often has a negative impact due to being considered a taboo subject. Vang (2011) cited Corrigan’s work

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from a 2007 study, in which Corrigan stated, “The negative effects of stigma include discrimination from the public and increases consumers’ reluctance to seek professional help” (p. 8). Participants indicated that back in Laos or Thailand, “there were severe cultural sanction if any behavior was seen as unacceptable,” and this practice “had carried over to the current day, even if someone was experiencing mental illness,” (Collier et al., 2011, p. 80).

In the qualitative study conducted by Lee et al. (2010) participants indicated that they were fearful of what the community may think of them that could result in losing face or feeling shameful which prevented them from seeking help. Lee et al. (2010) indicated that in Asian American communities, treatment for individuals would usually start with family members before seeking help outside due to the stigma associated with seeking help. For example, in this study (Lee et al., 2010), a focus group member indicated, “They probably won’t want to talk about it (depression or mental health problems) because sometimes people do know about the family (with mental illness) ... (and this impacts situations like) a daughter’s marriage (to) one of the family members with mental illness,” (p.337).

In the 2006 qualitative study conducted by Gensheimer (2006), a Hmong mental health provider explained that his elder participants would refer to medications that treat mental illness as “tshuaj vwm,” that translates as crazy drugs which indicates the stigma and lack of understanding or even use of terminology in mental health concepts. Gensheimer (2006) indicates that, “this stigma impacts the help-seeking behaviors of Hmong adults as well as their time for seeking Western mental health services,” (p. 16). For example, in this study Gensheimer (2006) a participant named Neng, “described how he attempted to explain mental health to a group of Hmong elders and how they responded to him by saying “tshuaj vwm, crazy

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drugs...dag xwb, it's a joke, it's fake...I don't believe in that stuff – that's just mumbo jumbo,” (p. 17). Hmong adults seeing that seeking psychological help as a socially undesirable quality and a sign of weakness may also hinder the views of the youth.

Adolescent participants in a quantitative study conducted by K. Vang, (2010) indicated that their families and friends may have unfavorable perceptions about mental health and “that discussing mental health was a “taboo” and as a result, elected to conceal, neglect, or deny their mental illness symptoms,” (p. 62). K. Vang (2010) discovered that perceived stigmatization was a barrier in utilizing mental health services for the Hmong youth. In this study (K. Vang, 2010), participants indicated that they would be embarrassed if parents and friends finding out about them receiving mental health services influenced their perception of stigmatization.

Accessibility and affordability. Accessibility and affordability were intermittently addressed as barriers throughout the articles reviewed. Studies indicated that Participant's lack of knowledge in the procedures and processes of mental health services served as barriers, in addition to participants' being unaware of the accessibility and affordability of the services. A qualitative study conducted in Eau Claire, Wisconsin by Collier et al. (2012) indicated that “payment for mental health services and psychotropic medication was reported as a barrier because they presented a financial hardship” (p. 82). Participants from the same study also indicated that there were delays in accessing providers and there were also limited organizations providing services from a culturally (specifically Hmong) sensitive lens in their area (Collier et al., 2012).

A quantitative study conducted by M. Vang, (2011) also indicated that participants expressed financial obstacles as a barrier that may deter them from seeking and staying in mental health

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treatment. According to M. Vang (2010), even though the majority (75%) of the respondents indicated they had health insurance through work or state programs, there were other respondents who indicated they did have any insurance coverage. M. Vang (2010) emphasized that financial obstacles may deter the Hmong people from utilizing mental health services.

A quantitative study conducted by K. Vang, (2010) involving Hmong youth indicated that participants were unsure how to access mental health services. K. Vang (2010) indicated that, “only one barrier was identified to be significantly related with attitudes towards seeking professional psychological help and that was Hmong students’ perceptions of the difficulties in making appointments and accessing such services,” (p. 59). K. Vang (2010) also emphasized that other researches have indicated that most Asian youth may not know how to utilize mental health services as they probably have had minimal experience in making health service appointments. K. Vang (2010) also emphasized that the annual household income for the majority of his sample size may fall under the state’s low-income health plans which may restrict mental health service usage.

Trust. Trust was another theme that was only nominally addressed throughout the articles reviewed. Lack of trust was described as another obstacle that discourages Hmong people from seeking or utilizing mental health services, as it was difficult for them to disclose personal information openly. Participants in a study conducted by Johnson (2002) indicated that their past “experiences in the Western medical system medical system are shared in the Hmong community and cause the Hmong to be afraid of hospital experiences and to mistrust Western medical providers,” (p. 130). Hmong participants feared that they would be guinea pigs and experimented on if they seek western medical attention. For example, “They fear surgery and

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Western medicine because they have heard rumors that “experiment on Hmong people,” and they perceive that the “student doctors” (residents) are there to learn and the Hmong people are used for practice,” (Johnson, 2002, p. 130). Johnson (2002) emphasized that the Hmong participants felt that the treatments offered by the doctor are only beneficial to the doctors’ learning.

A qualitative study conducted by T. Lee (2010) involving Hmong men ages 35 to 65 indicated that distrust with sharing problems were barriers to utilizing mental health services. For example, a participant from the study that T. Lee, (2010) indicated:

“I never share my personal problems with anybody and I always solve my personal problems by myself. I told myself that I am the only person that can solve my own problems. If I cannot help myself, then nobody else can help me. This is my mentality. I never trust or rely on other people to help me. For example, when I have a financial problem; can anybody help me? No, I do not think so because they cannot just give me money,” (p. 30)

Another participant in the same study (T. Lee, 2010) indicated that he would not share any personal issues especially if a Hmong interpreter was present:

“I will never go see a therapist or a counselor if I still need a Hmong interpreter. I never feel comfortable having a Hmong interpreter knowing about my personal problems. I do feel comfortable and trust mental health professionals who are not Hmong, because they do not know me personally and have fewer changes of seeing me in the community. At the same time, I also

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feel uncomfortable having an interpreter, because I do not trust his/her professionalism and I may not tell my whole story to my therapist or doctor,” (p.31).

Discussion

Summary of Articles

The purpose of this systematic review was to synthesize relevant literature to identify the barriers to seeking mental health services for the Hmong. Articles pertaining to the Hmong population, specifically around mental health services were selected through inclusion and exclusion criteria. After conducting analysis of the literature, six interrelated themes emerged as indicators of obstacles to seeking mental health services for the Hmong: 1) cultural practices and beliefs, 2) mental health literacy, 3) language barriers, 4) stigma, 5) accessibility and affordability and 6) trust.

Eight research articles backed up the theme that cultural practices and beliefs contributed to obstacles in providing mental health services. The article, *Learning from the experiences of Hmong mental health providers* (2006), conducted by Gensheimer indicated that Hmong participants preferred to seek consultations or treatments from a traditional shaman over western health care services because they believed that traditional methods may cure their mental health symptoms faster. An individual's decision may affect the family, so they must consult with family members before making a decision on their own (Johnson, 2002). In A quantitative study conducted by M. Vang (2011), emphasized that many of the respondents preferred to seek help from family before seeking help elsewhere. A qualitative study, *Obstacles to parent – adolescent communication in Hmong American families* conducted by Meschke et al. (2014), emphasized that freedom of expression of personal issues were not normal practices of the Hmong culture which created barriers to seeking mental health services for the Hmong.

Eight research articles backed up the theme that mental health literacy contributed to obstacles in providing mental health services. The article, *Mental health literacy in Hmong and Cambodian elderly refugees* by Lee et al. (2010), highlighted that Hmong elderly are unaware of mental illnesses due to the limited terminology in their language and lack of understanding the treatment in mental health services. Another article, *Hmong mental health needs assessment* (2011) by Collier et al., emphasized the lack of awareness about how to and when to seek mental health services influences the avoidance in utilizing mental health services. The findings suggested that the Hmong lacked the basic understanding of mental health illnesses, symptoms, terminologies and the process of treatments which deterred them from seeking mental health services. Participants struggled with identifying symptoms and terminologies and expressed that their symptoms originated from external circumstantial situations and if those issues were resolved their symptoms would be cured (Lee et al., 2010).

Seven research articles backed up the theme that language barriers contributed to obstacles in providing mental health services. The article, *Mental health literacy in Hmong and Cambodian elderly refugees* (2010) by Lee et al., emphasized that interpreting mental health terminologies into the Hmong language may difficult and create barriers in providing mental health services to the Hmong. The findings suggested that mental health is a new concept to the Hmong and they face challenges with finding terms to translate in their native language appropriately. Since there is a lack of knowledge and terminology about mental health, interpreters indicate the difficulty with translating as they will have to explain the concept or theory to get the message across (Barret et al., 1998). Participants indicated that due to language barriers, seeking mental health services was not an interest as they did not feel comfortable

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disclosing personal information and felt that they couldn't get their message across even through use of translation services (T. Lee, 2010).

Six research articles backed up the theme that stigma contributed to obstacles in providing mental health services. The article, *Mental Health needs assessment* (2011) by Collier et al., indicated that there would be repercussions back in their home (Laos or Thailand) for improper behavior and felt that that practice which influenced many Hmong participants to not utilize mental health services. The article, *Learning from the experiences of Hmong mental health providers* (2006) by Gensheimer, indicated participants associated medications to treat mental illness symptoms as “tshuaj vwm” (interpreted as “crazy drugs”) and expressed no desire to seek mental health services.

Three research articles backed up the theme that affordability and accessibility were obstacles in providing mental health services. The findings suggested that accessibility and affordability were obstacles that discouraged the Hmong from seeking mental health services. The article, *Mental Health needs assessment* (2011) by Collier et al., emphasized that mental health services would prove to be a financial burden for participants to continue as services do not provide quick fixes and are usually long term. The article, *Cultural and environmental factors that help or deter the Hmong from seeking mental health services* (2011) by M. Vang, highlighted that financial obstacles may deter the Hmong people from utilizing mental health services.

Two research articles backed up the theme that trust was an obstacle in providing mental health services. The findings suggested that trust was a barrier that deters the Hmong from seeking mental health services. Many past experiences with Western medical providers are

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usually shared amongst the Hmong community. Participants indicated that they didn't trust the Western medical system from stories they've heard through family members or friends (Johnson, 2002). The article, *What are the Barriers to First Generation Non-Christian Hmong Men ages 35 to 65 seeking mental health services* (2010) by T. Lee, indicated that lack of trust in mental health providers and interpreters were barriers to utilizing mental health services.

In conclusion, the findings in this systematic review suggests that the following: cultural practices and beliefs, mental health literacy, language barriers, stigma, accessibility and affordability and trust are all obstacles that discourage the Hmong from seeking mental health services. Cultural practices and beliefs are passed down through generations for the Hmong and it is evident that perceptions or stigma associated with mental illness influences the utilization of mental health services. The association of stigma and lack of knowledge about mental health illnesses, symptoms or treatments are barriers to seeking mental health services for the Hmong. If knowledge does not exist, superstitions will exist and with the Hmong, the stigma that is associated with mental health originates from the lack of mental health literacy. Interpreting is a challenge due to limited terminology explaining definitions of mental illnesses or symptoms resulting in language barriers and discouragement for the Hmong to seek mental health services. In some articles, participants indicated their interest in utilizing mental health services; however, expressed that affordability and accessibility would be barriers for them to seek or stay in treatment.

Limitations and recommendations for future research

Even though this systematic review was created to include all relevant literature relating to the barriers to accessing mental health services for the Hmong, there were limitations to this study. The concept of mental health is fairly new to the Hmong and there were limited amount of literature specifically focusing on mental health and the Hmong. In many cases in which there was relevant literature, the Hmong would often be grouped with other Southeast Asian groups in the sample sizes. The sample size of literature was minimal and a larger sample size may have captured more data to analyze. The total sample size was minimal (10 articles, eight articles focusing on mental health services and two focusing on medical services); a larger sample size may have captured more data to analyze.

Another limitation was the design of the research. A systematic review only allowed the researcher to analyze selected data that have been analyzed from previous studies. A face to face interaction with participants or qualitative design regarding barriers to accessing mental health services may have captured a richer and broader range of data regarding this emerging topic. A quantitative design may have been able to capture a broader range of data regarding barriers to seeking mental health services for the Hmong.

The researcher recommends a qualitative study with Hmong participants to better understand ways to alleviate barriers in accessing mental health services. Having the Hmong provide suggestions on ways to reduce the obstacles may help identify better strategies or approaches when working with the Hmong in mental health settings. Another recommendation would be a longitudinal study with Hmong participants to see how effective mental health services are with participants over time. Since the Hmong can be skeptical about mental health

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services and usually share past experiences amongst each other in the community, a longitudinal study may capture the effectiveness of mental health services and, potentially ameliorate some concerns.

Implications for Social Work Practice

This research provides insight about the barriers that deter the Hmong from seeking mental health services. The findings indicated that these factors: cultural practices and beliefs, mental health literacy, language barriers, stigma, trust and accessibility and affordability are obstacles that discourage the Hmong from seeking mental health services. The findings indicated how these barriers influence the Hmong perception and utilization of mental health services. The findings also indicate there is lack of basic knowledge and terminologies about mental health which may influence the stigma associated with mental health for the Hmong.

This research brings understanding and awareness of the struggles that a Hmong individual may face when utilizing mental health services. This research provides some insight on being mindful of the cultural practices and beliefs when working with the Hmong on how to recognize the causation of illnesses. It also reinforces a notion that a one-size-fits-all approach to mental health service will exclude individuals and families to care they need and deserve.

Providing more psycho-education on mental health and dialogue in the Hmong community may bridge the gap in the lack of knowledge of mental health and decrease stigma or stereotypes. Providing more culturally appropriate and sensitive approaches or techniques when working with Hmong individuals in the mental health setting is also recommended. This research also brings attention to understanding that translation may even be a barrier and working closely with interpreters to capture the desired message from the Hmong individual is also of tremendous importance in mental health care. While the mental health industry may utilize this research to strengthen treatment approaches, it is also essential to note that proactive, intentional, and community-based strategies for outreach and engagement must also be part of assisting the

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Hmong community in overcoming barriers. It may be inferred, from this research, that, if, Western medical model systems of care continue to serve as the dominant way of delivering mental health services, without flexibility, innovation, or accommodation, this cultural community will likely continue to underutilize services intended to promote greater health and wellness for individuals and families. In order to join the Hmong community in overcoming such barriers, mental health professionals must first become aware of these obstacles and then develop and sustain a commitment at individual, agency and policy levels to eliminating them.

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